

Flexibilities Implemented for Comprehensive and Supports Waiver Programs in Response to COVID-19

The following guidelines for providers of Comprehensive and Supports Waiver services are specific to the Division's response to Coronavirus Disease 2019 (COVID-19).

Identified flexibilities are specific to this crisis, will only be implemented upon notification of the Division, and will be rescinded when the Division determines the flexibilities are no longer necessary.

Guidelines for Case Management Services

- Effective March 13, 2020, and until further notice, case managers may conduct individualized plan of care (IPC) development and monitoring activities, including plan of care team meetings, home visits, and service observations, by telephone or video conference as an alternative to in-person case management visits. A home visit is still required, but it is up to the case manager and participant or legally authorized representative to decide if the visit should be conducted in person or via telephone or video conference.
 - If the home visit is conducted via telephone or video conferencing, documentation of the visit will still be required. Please see the [additional guidance on documentation expectations](#).
 - If the home visit is conducted via telephone or video conferencing, it is appropriate to talk to provider staff members regarding specific concerns, challenges, or activities. However, the intent of the home visit is to talk to the participant, and this interaction is still expected to be the majority of the visit.
 - Telephone or video conferencing is an option; however, the Division does not require that the home visit be conducted from a remote location. If the case manager, participant, and family or provider agree that in person visits are safe, then visits may take place on-site.
 - If the participant who has communication challenges doesn't have access to video conferencing equipment (phone, tablet), and the team determines that an on site visit is not in the best interest of the participant, then the team should work together to identify strategies to make case manager contact with the participant possible.
- All case management activities that are required in order to bill for a monthly unit, as established in the Comprehensive and Supports Waiver Service Index, are still required, including, but not limited to:
 - A minimum of two hours of billable services;
 - A home visit; and
 - An hour of person to person contact with the participant or legally authorized representative.
 - Person to person contact can occur via telephone or video conferencing. The hour of person to person contact required in order to bill a monthly case management unit may occur over several shorter timeframes (i.e., four 15-minute visits).
 - The home visit and hour of person to person contact must be individualized. Regardless of whether the contact and home visit occurs in-person, via telephone, or via video, case managers must use that time for contact with an individual participant. These visits cannot be combined to bill for multiple participants at the same time.
 - During the health crisis, the one hour of person to person contact may include provider contact, as long as the participant continues to receive ongoing services from the provider.

- The case manager can modify the plan to include 15-minute case management units if they will not be able to meet the requirements for a monthly case management unit. The 15 minute and monthly unit shall not be billed in the same month.
- The Division will accept required forms and program materials without the required signatures if the form includes documentation that the activity was conducted remotely (such as through documentation of an email thread). Information on current expectations can be found in the [Comprehensive and Supports Waiver Service Index](#) (Service Index).

Modifications to Community Support Services

Effective March 17, 2020, and until further notice, participants can receive community support services in their home, with the following conditions:

- This change in setting must be approved by the participant or legally authorized representative. This approval must be obtained in writing (i.e., email, written note, text message) by either the case manager or provider, and must include the reason for the change in settings and the date the approval is effective. Services in the home may be provided prior to the written documentation being obtained as long as verbal approval has been given.
- The IPC does not need to be updated, but the written documentation of the approval must be available to the Division upon request.
- Providers of this service will need to ensure that the service being delivered meets the service definition and the needs of the participant, as outlined in the IPC. Objectives should be focused on community access. This service should look different than community living services, and should not replicate the services typically delivered in the home.
- The high level of care tiered rate allowed for individual time spent solely in the community must not be billed while the participant is receiving services in their home.

The current Community Support Services definition does not exclude the provision of services through teleconferencing. This service may be delivered through teleconferencing as long as it meets the needs of the participant, as outlined in the IPC.

Modifications to Adult Day Services

The current Adult Day Services (ADS) description allows the service to be provided in the participant's home "if the participant/legally authorized representative and the plan of care team decides the home is a more appropriate place to receive the service and the approved plan of care supports the medical, behavioral, or other reason for the service to be provided in the participant's home."

- Effective March 13, 2020, and until further notice, if the participant, legally authorized representative, and plan of care team decides that it is in the best interest of the participant to receive ADS in the home during the COVID-19 crisis, then the services may be provided in the home. This change in setting must be approved by the participant or legally authorized representative. This approval must be obtained in writing (i.e., email, written note, text message) by either the case manager or provider, and must include the reason for the change in settings and the date the approval is effective. Services in the home may be provided prior to the written documentation being obtained as long as verbal approval has been given.

- A modification will not be required as long as ADS is authorized on the current IPC and the number of units is not changing. However, the written documentation of the approval must be available to the Division upon request.
- Providers of this service will need to ensure that the service being delivered meets the service definition and the needs of the participant, as outlined in the IPC. This service should look different than community living services, and should not replicate the services typically delivered in the home.

The current Adult Day Services definition does not exclude the provision of services through teleconferencing. This service may be delivered through teleconferencing as long as it meets the needs of the participant, as outlined in the IPC.

Modifications to Community Living Services - Basic 15 Minute Unit

Effective April 2, 2020, and until further notice, a participant who is receiving basic 15 minute units of Community Living Services may receive that service through teleconferencing if the service can be appropriately delivered through this technology, with the following conditions:

- Providers of this service will need to ensure that the service being delivered meets the service definition and the needs of the participant, as outlined in the IPC.
- This change in service delivery must be approved by the participant or legally authorized representative. This approval must be obtained in writing (i.e., email, written note, text message) by either the case manager or provider, and must include the reason for the change in settings and the date the approval is effective. Services through teleconferencing may be provided prior to the written documentation being obtained as long as verbal approval has been given.
- A modification will not be required as long as 15 minute units are authorized on the current IPC and the number of units is not changing. However, the written documentation of the approval must be available to the Division upon request.
- A modification will be required if 15 minute units need to be added to the IPC. Plan of care teams must adjust service units to ensure that the IPC accounts for services to cover the entire plan year. Please be advised that additional funding is not available to increase IBAs. All waiver services must be provided within the participant's current IBA.
- In the event of a participant emergency, or upon the request of the participant, the provider must be available to respond in person.
- Providers are still required to meet documentation standards as outlined in Chapter 45, Section 8 of the Department of Health's Medicaid Rules.
- Within the guidelines issued by federal, state, and local officials, the participant must have access to their community to the same degree as other citizens. When reasonable, face to face interaction is still the preferred method of service delivery.

This flexibility is not available for participants receiving Community Living Services Basic daily or Community Living Services tier levels 3 - 6.

Modifications to Occupational Therapy, Physical Therapy, and Speech, Language, and Hearing Services

Effective April 2, 2020, and until further notice, a participant may receive Occupational Therapy, Physical Therapy, or Speech, Language and Hearing Services through teleconferencing as long as this service is approved

by the therapist's licensure board and the needs of the individual can be appropriately addressed in this manner. A modification to the IPC will not be required.

Modifications to Companion Services

Effective April 2, 2020, and until further notice, a participant who is receiving Companion Services may receive that service through teleconferencing if the service can be appropriately delivered through this technology, with the following conditions:

- Providers of this service will need to ensure that the service being delivered meets the service definition and the needs of the participant, as outlined in the IPC.
- This change in service delivery must be approved by the participant or legally authorized representative. This approval must be obtained in writing (i.e., email, written note, text message) by either the case manager or provider, and must include the reason for the change in settings and the date the approval is effective. Services through teleconferencing may be provided prior to the written documentation being obtained as long as verbal approval has been given.
- In the event of a participant emergency, or upon the request of the participant, the provider must be available to respond in person.
- Providers are still required to meet documentation standards as outlined in Chapter 45, Section 8 of the Department of Health's Medicaid Rules.
- Within the guidelines issued by federal, state, and local officials, the participant must have access to their community to the same degree as other citizens. When reasonable, face to face interaction is still the preferred method of service delivery.

Guidelines for community access

Participants have access to the community to the same degree as people who are not receiving home and community based waiver services. Unless sheltering in place for the community is specifically ordered by State or Federal authorities, participants may access their community. Providers and plan of care teams should encourage participants to follow [established guidelines for health and safety](#), implement social distancing, and exercise caution when in the community. Providers who are supporting people in the community should exercise these cautions as well.

Guidelines for visitors in the participant's home

Effective March 13, 2020, and until further notice, a participant's right to have visitors of their choosing at any time may be temporarily restricted in the following circumstances:

- The participant has a confirmed diagnosis of COVID-19;
- The participant is awaiting results of a COVID-19 test; or
- The participant has had direct contact with an individual who is presumed to have COVID-19.

Providers may establish policies that limit visitors in a provider owned and operated residence in order to minimize the spread of infection during the COVID-19 pandemic. Although limiting visitors is acceptable during this health emergency, the following visitors must be allowed:

- Legally authorized representatives of participants living in the residence;
- Case managers
- Division, Department of Family Services, and Protection and Advocacy Systems, Inc. representatives;
- Law enforcement; and

- Emergency medical responders.

Limitations to visitors must be imposed in a way that has the least impact on each participant's right to have visitors of their choosing. As an example, if a participant would like to have a friend over, providers should be creative in encouraging the interaction, while still maintaining social distancing and other health related best practices. Providers may elect to implement strategies, such as visitor screenings, prior to visitors entering the residence.

This temporary allowance does not give providers authority to prohibit participants from accessing the community.

Individual budget amounts (IBAs)

Additional funding is not available to increase IBAs at this time. All waiver services must be provided within the participant's current IBA.

Waiver services during school closures

The Division understands the hardship that having school districts close creates. Effective immediately, and until further notice, Respite Services may be used while the primary caregiver is at work.

School aged children may receive Respite, Individual Habilitation Training, *Personal Care* or Child Habilitation Services during regular school hours when local school districts are closed due to the COVID-19 crisis. Participants who typically attend school and are 18 years or older may use Companion Services.

Schools are considered to be in session if students are engaging in educational activities. If a student who typically receives special education services is engaging in educational activities, they are required to have an Individual Educational Plan (IEP). The local school district is responsible for supplying and funding all educational services established in a student's IEP, in accordance with the Individuals with Disabilities Education Act (IDEA).

The IEP Team and waiver case manager must work together to clearly define what the student's day looks like during the COVID-19 health emergency, including when the student will and will not be engaging in educational services. This information must be clearly identified in the IEP, which cannot be changed without prior written notice (PWN) and documentation that the parent or legally authorized representative participated in the process. Prior written notice may take many forms, but is essentially clearly communicated documentation of what the student's school day will look like during the COVID-19 emergency, or what has changed from the IEP that was in place prior to the COVID-19 emergency.

If the student has outstanding needs during the time that educational activities are taking place, it is the responsibility of the local school district to ensure that those needs are met. The school district and IEP Team are tasked with developing and implementing solutions to meet each student's needs.

Each school district has a [Special Education Director](#) who is responsible for the oversight of IEPs for students within that district. If you have questions regarding a student's educational needs, please contact the Special Education Director for the student's district to seek further guidance.

If a child requires services during the day **and** they are not receiving educational services outlined in the IEP, then they may receive waiver services.

Plan of care teams must adjust service units to ensure that the IPC accounts for services to cover the entire plan year. Please be advised that additional funding is not available to increase IBAs. All waiver services must be provided within the participant's current IBA.

For more information on special education services during the COVID-19 health emergency, please visit <https://edu.wyoming.gov/educators/covid-19-resources/>.

Provider certifications and staff qualifications - *Updated August 25, 2020*

Effective immediately, and until further notice, the Division will extend provider certification renewals for all providers through June 30, 2020. Providers will receive notification of their updated expiration dates, and will receive notification regarding certification renewal deadlines per Chapter 45, Section 28 of the Department of Health's Medicaid Rules. This temporary extension of provider certification renewals also applies to renewal activity in process. Providers will be expected to remain in compliance with all documentation standards, reporting requirements, and other provisions established in Chapter 45 of the Department of Health's Medicaid Rules. Additionally the Division will limit on-site visits as a result of a complaint or incident to those for which participant health and safety concerns are identified.

Chapter 45, Section 13(e) requires providers to obtain an inspection of provider owned settings by an outside entity every 24 months. This requirement will be relaxed for the duration of the health emergency. If a provider needed to obtain this inspection during the health emergency, providers will have 30 calendar days to schedule this inspection once the emergency declaration expires.

If a provider employee has a required certification expire due to training cancellations during the COVID-19 crisis (i.e., First Aid, CPR, Mandt), the provider will need to document the reason for the expiration in the employee's file. Upon notification from the Governor that the crisis has passed, the employee will have 30 calendar days to schedule training. Please note that some organizations, such as the American Heart Association, may grant extensions of certification due to cancellations. If the organization grants such an extension, maintain documentation of this extension for your records.

Division supplied Medication Assistance Training has been suspended until further notice. Medication Assistance Training certifications and Medication Assistance Training Instructor certifications will be considered valid until such time as the Division deems it safe to resume Division supplied Medication Assistance Training. Upon notification from the Division, providers, provider staff members, and self-directed employees will have 30 calendar days to schedule Medication Assistance Training. Individuals who have not received Medication Assistance Training in the past should not assist participants with medications until the required training is completed.

Fingerprint background screening requirements for new employees, and subsequent fingerprinting for existing employees are temporarily suspended. Upon notification from the Governor that the crisis has passed, the employee will have 30 calendar days to submit their fingerprints. The Department of Family Services Central

Registry and Office of Inspector General Exclusion Database screenings are still required, as established in Chapter 45, Section 14.

If an employee's crisis intervention training has expired, they should not perform a restraint. Although the Division will not enforce the training requirement during the COVID-19 crisis, the provider will be responsible for any harm that comes to a participant as a result of inadequate staff training. Please also note that incident reporting requirements are currently still in place.

Continuation of services

Chapter 45, Section 22 requires providers to notify the participant and Division, in writing, at least thirty calendar days prior to ending services, unless the Division approves a shorter transition period in advance. At this time, providers must comply with the 30 day notice for all direct and non-direct services, or be considered in abandonment of services.

In accordance with Chapter 45, Section 13(g), providers should have written emergency plans and procedures, which include contingency plans that assure that there is a continuation of essential services when emergencies occur. The Division encourages all providers to be proactive in implementing their plans, and make revisions and updates based on what they learn through this experience.

All plan of care teams, including participants, legally authorized representatives, providers, case managers, and friends and family, should work together to ensure that the needs of the participant are met.

Participant exposure to, or diagnosis of, COVID-19

The Division strongly encourages all citizens in Wyoming to use the [guidelines](#) provided by the Centers for Disease Control and Prevention (CDC) in order to prepare and take action for COVID-19. If a person is diagnosed with COVID-19, assist them in understanding and following the instructions provided by their healthcare workers, and take necessary precautions to limit or personal exposure when providing services to someone who is sick. If a person is exposed to COVID-19, assist them in understanding and following the instructions provided by the Wyoming Department of Health, Public Health Division.

Providing support to participants while they are hospitalized

Effective March 13, 2020, and until further notice, participants who require hospitalization will be allowed to receive the following services in a hospital setting when the participant requires these services for communication, behavioral stabilization, or intensive personal care needs:

- Adult Day Services
- Community Living Services
- Companion Services
- Personal Care Services

Incident reporting

Chapter 45, Section 20(b) requires that identified incidents, which include medical or behavioral admission and emergency room visits that are not scheduled medical visits, be reported within one business day. If a participant goes to the emergency room, or is hospitalized, an incident report will need to be filed.

Although having a participant diagnosed with COVID-19 is not in itself a reason to file an incident report, the Division encourages providers to keep in contact with us with any emerging concerns. If emergency care is sought as a result, please follow reporting requirements as appropriate. We need to be aware of the actual challenges that are being faced so that we can determine how to best support participants and providers during this unprecedented time.

Potential flexibilities and service changes

The Division is in regular contact with the Centers for Medicare and Medicaid Services (CMS), as well as our national association and colleagues in other states, to stay up-to-date on the waiver flexibilities that are available. Flexibilities could include additional temporary changes to service definitions, provider certifications, and provider types. When considering flexibilities, the Division will continue to balance participant health, rights, and person-centered services with public safety recommendations and the challenges faced by our provider community.

Emergency medical supplies such as masks and gowns will not be covered through waiver funds.

At this time, the Division has implemented several flexibilities, which are included in this document. However, unless notified by the Division, providers must provide the support and supervision levels that are outlined in each participant's IPC.

Participants who stay with family for more than 90 days

Some families may choose to have their loved one stay with them until the COVID-19 crisis is over. During this time, case managers may still provide services, even if they are limited. As long as case management services are provided, the participant will not lose their waiver funding, even if they are with their family beyond 90 days.

Ongoing surveys and assessments

Until further notice, the Division of Healthcare Financing (Division) has temporarily authorized psychological and neuropsychological assessments conducted for the purpose of determining Comprehensive and Supports Waiver participant eligibility to be performed via video conferencing.

Until further notice, the Wyoming Institute for Disabilities (WIND) will be conducting Inventory for Client and Agency Planning (ICAP) assessments via teleconferencing.

Until further notice, National Core Indicator (NCI) Adult In Person surveys have been suspended. The NCI Staff Stability survey is not an in person survey. Providers who have been selected to participate in this survey are requested to complete and submit the survey by the June 30, 2020 deadline.

Temporary rate increase for specific DD Waiver services

The Division has identified the need to temporarily increase certain provider reimbursement rates for traditional Comprehensive and Supports Waiver services. In order to maintain the direct support professional workforce and account for increased overtime pay, this temporary reimbursement rate increase will be effective as of March 13, 2020, and will expire on September 1, 2020. Temporary rate increase amounts can be found on the [COVID-19 Temporary Fee Schedule](#).

This temporary rate increase will not be subtracted from participant individual budget amounts (IBAs), nor will it affect participant purchasing power. Case managers will not be required to modify IPCs or calculate units that will be impacted by this increase.

The temporary increase will be implemented in two phases. The first phase will address services billed from April 23, 2020 through August 31, 2020. The second phase will address the retroactively applied increase for services between March 13, 2020 and April 23, 2020 that have already been billed.

Temporary self-directed budget increases

As part of the Wyoming Department of Health's effort to address continuing challenges associated with the COVID-19 public health emergency, the Division will allow for a temporary 12.5% increase to a portion of participant self-directed budgets. This amount is consistent with the temporary reimbursement rate increase for traditional service providers, as communicated on April 23, 2020, and intended to ensure the continuity of the direct support professional workforce. This increase is earmarked for the purpose of increasing employee wages, and cannot be used to add additional services to the participant's individualized plan of care (IPC). If the employer of record (EOR) chooses to increase employee wages for existing services, the increase may go into effect no earlier than the pay period beginning June 1, 2020. This temporary increase will expire on September 1, 2020.

In order to calculate and implement this increase, case managers and EORs must complete specific steps. Please refer to the Information on Temporary Self-Directed Budget Increases toggle on the [Coronavirus Disease 2019 Updates for DD Waiver Services](#) page of the Division website for more information on the responsibilities of the case manager and EOR.

This temporary increase will not be evident in the Electronic Medicaid Waiver System (EMWS). However, the EOR will see an increase in the participant's self-directed budget on the ACES\$ portal equal to three months. Increases for three month increments will be added to the self-directed budget through August 31, 2020.

Although the additional funding for temporary wage increases will not be effective until June 1, 2020, case managers and EORs are encouraged to begin submitting necessary paperwork to the Division and ACES\$ as soon as possible if the EOR wishes to increase a wage by the effective date. These increases are not retroactive. Employees cannot be paid the higher wage until all steps outlined above have been completed.